

pregnancy-induced hypertension or a history of decreased fetal movement supported by persistently poor fetal testing over one to two days. Pregnancy should rarely be carried beyond 40 weeks except in women well controlled by diet with no other risk factors. In such situations, fetal surveillance should be used until cervical ripening or 42 weeks of gestation. Elective interventions, such as a cesarean section at 38 weeks or inductions of labor, should be preceded by evidence of fetal lung maturity.

The long-term morbidity of gestational diabetes includes type II or non-insulin-dependent diabetes mellitus. This disorder in turn is associated with a higher frequency of end-organ failure, such as kidneys, eyes, and heart, especially in minority populations. Continued attention to diet, weight control, and exercise may reduce these risks.

At eight weeks postpartum, women with gestational diabetes mellitus should be tested with a standard 75-gram, two-hour glucose tolerance test. Women with abnormal test results should be seen by a diabetologist.

Although the risk of congenital anomalies is not reduced by diagnosing diabetes during pregnancy, this approach identifies a population that should undergo preconception counseling. Such counseling begins before the next pregnancy, which should be planned. It encourages women at risk for gestational diabetes to begin good glucose control two to three cycles before a planned pregnancy. This approach is associated with a substantial reduction in congenital anomalies.

JOSEPH L. HARRIS, MD
Los Angeles, California

REFERENCES

- Cousins LM, Baxi L, Chev R, et al: Screening recommendations for gestational diabetes mellitus. *Am J Obstet Gynecol* 1991; 165:493-496
- Landon MB, Gabbe SG: Fetal surveillance in the pregnancy complicated by diabetes mellitus. *Clin Obstet Gynecol* 1991; 34:535-543
- Landon MB, Gabbe SG, Sachs L: Management of diabetes mellitus and pregnancy: A survey of obstetricians and maternal-fetal specialists. *Obstet Gynecol* 1990; 75:635-640

study found that daily treatment of endometriosis with RU 486 for three months led to a relief of symptoms without objective lessening in the extent of disease.

RU 486 may have applications beyond reproductive medicine. For example, the drug might be useful in treating women with metastatic breast cancer resistant to current therapies. In a study of 22 women after menopause or oophorectomy with therapy-resistant metastatic breast cancer, 18% showed a response to the drug at three months. When given in doses larger than that required to block progesterone receptors, RU 486 also blocks glucocorticoid receptors; the drug has been shown to be useful in treating Cushing's syndrome. Studies of its use in treating glaucoma and meningioma are in progress.

DAVID A. GRIMES, MD
Los Angeles, California

REFERENCES

- Kettel LM, Murphy AA, Mortola JF, Liu JH, Ulmann A, Yen SSC: Endocrine responses to long-term administration of the antiprogestone RU 486 in patients with pelvic endometriosis. *Fertil Steril* 1991; 56:402-407
- Puri CP, Van Look PFA: Newly developed competitive progesterone antagonists for fertility control. *Front Horm Res* 1991; 19:127-167
- UK Multicentre Trial: The efficacy and tolerance of mifepristone and prostaglandin in first trimester termination of pregnancy. *Br J Obstet Gynaecol* 1990; 97:480-486

Management of Hirsutism

HIRSUTISM, or male-pattern hair growth in women, is a common cosmetic complaint. The differential diagnosis includes pathophysiologic processes that either increase androgen production (polycystic ovary syndrome, late-onset congenital adrenal hyperplasia, Cushing's syndrome, or neoplasm) or increase androgen activity at the hair follicle itself (increased 5α -reductase activity). Regardless of the cause, the presence of hirsutism implies a net hyperandrogenic effect at the hair follicle. Evaluation requires a careful physical examination and the measurement of serum androgens (testosterone and dehydroepiandrosterone). The physical examination should include areas of male-pattern hair growth such as the upper lip, chin, neck, midline chest, and lower abdomen. If serum androgen levels are elevated—testosterone greater than 1.8 nmol per liter, dehydroepiandrosterone greater than 9.5 μ mol per liter—then disorders of androgen overproduction such as polycystic ovary syndrome or late-onset congenital adrenal hyperplasia should be considered. If serum androgen levels are normal, then increased 5α -reductase activity is diagnosed by exclusion. Once a diagnosis has been made, treatment can be considered. The cornerstones of medical treatment involve inhibiting adrenal or ovarian androgen production; altering androgen binding to sex hormone-binding globulin (SHBG); or blocking androgen receptors.

Ovarian androgen production can be suppressed in several ways. The use of combination estrogen-progestin (oral contraceptive) therapy lowers free testosterone levels by suppressing ovarian production of androgens and increasing SHBG. Because hirsutism is commonly associated with menstrual irregularities, oral contraceptives can also provide menstrual cycle control. Gonadotropin-releasing hormone agonists, such as leuprolide acetate or nafarelin acetate, have been used successfully to treat hirsutism by inhibiting ovarian androgen production. Because of the effects of estrogen deprivation, however, long-term treatment with these agents is not feasible.

Selective suppression of adrenal androgen production may be induced with low dosages of dexamethasone. This is

RU 486 (Mifepristone)

RECENTLY APPROVED for use as an abortifacient in the United Kingdom and in France, RU 486 (mifepristone) is the first of a new class of antiprogestins. When given in early pregnancy, it saturates progesterone receptors in the endometrium but does not act as an agonist. Progesterone is essential to sustain an early pregnancy, and if its action is blocked by RU 486, an abortion ensues. When given in a single oral dose of 600 mg before seven weeks' gestation, abortion rates of 80% to 90% can be achieved. If the dose of RU 486 is followed in 36 to 48 hours by a small dose of prostaglandin, the efficacy increases to more than 90%. The prostaglandin can be given as an intramuscular injection, a vaginal suppository, or orally by tablet. In the largest series of such abortions reported from France, the abortion rate was 96%. Morbidity rates have been low, although heavy bleeding can require curettage for management.

RU 486 may have a broad range of uses in reproductive medicine. When given to both pregnant and nonpregnant women, it causes softening and dilation of the cervix. When given 24 hours before beginning a second-trimester abortion by labor induction, it can reduce the time required by more than 50%. Its usefulness for inducing labor at term remains to be studied. Experience with RU 486 as medical therapy for ectopic pregnancy has not been encouraging. One small